STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	005106	A. BUILDING: _____ B. WING _____	09/16/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COMMUNITY HOSPITAL	901 MACARTHUR BLVD MUNSTER, IN 46321

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S 000	INITIAL COMMENTS This survey was for the investigation of two State complaints. Complaint numbers: #IN00141382: Substantiated; no deficiencies related to the allegations are cited #IN00145224: Unsubstantiated; lack of sufficient evidence Date of Survey: 9/16/2014 Facility #: 005106 Surveyor: Nancy Otten, RN Public Health Nurse Surveyor Community Hospital is in compliance with 410 IAC 15-1.5-6, Nursing services and 410 IAC 15-1.5-10, Utilization review and discharge planning, Hospital Licensure Rules. QA: 10/17/14	S 000		